Mercy Care Plan

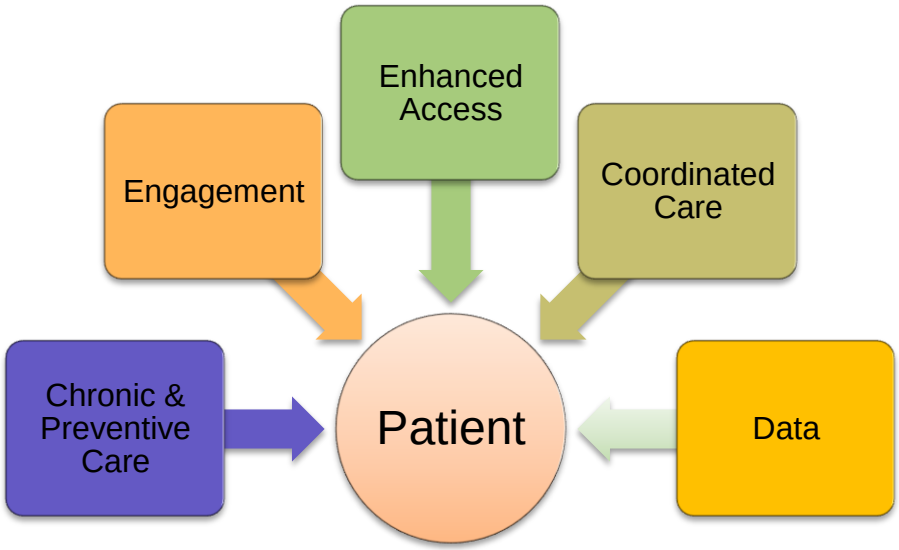
Patient Centered Medical Homes
Transforming Patient Care

Presented by Dana Pepper

August 24, 2012

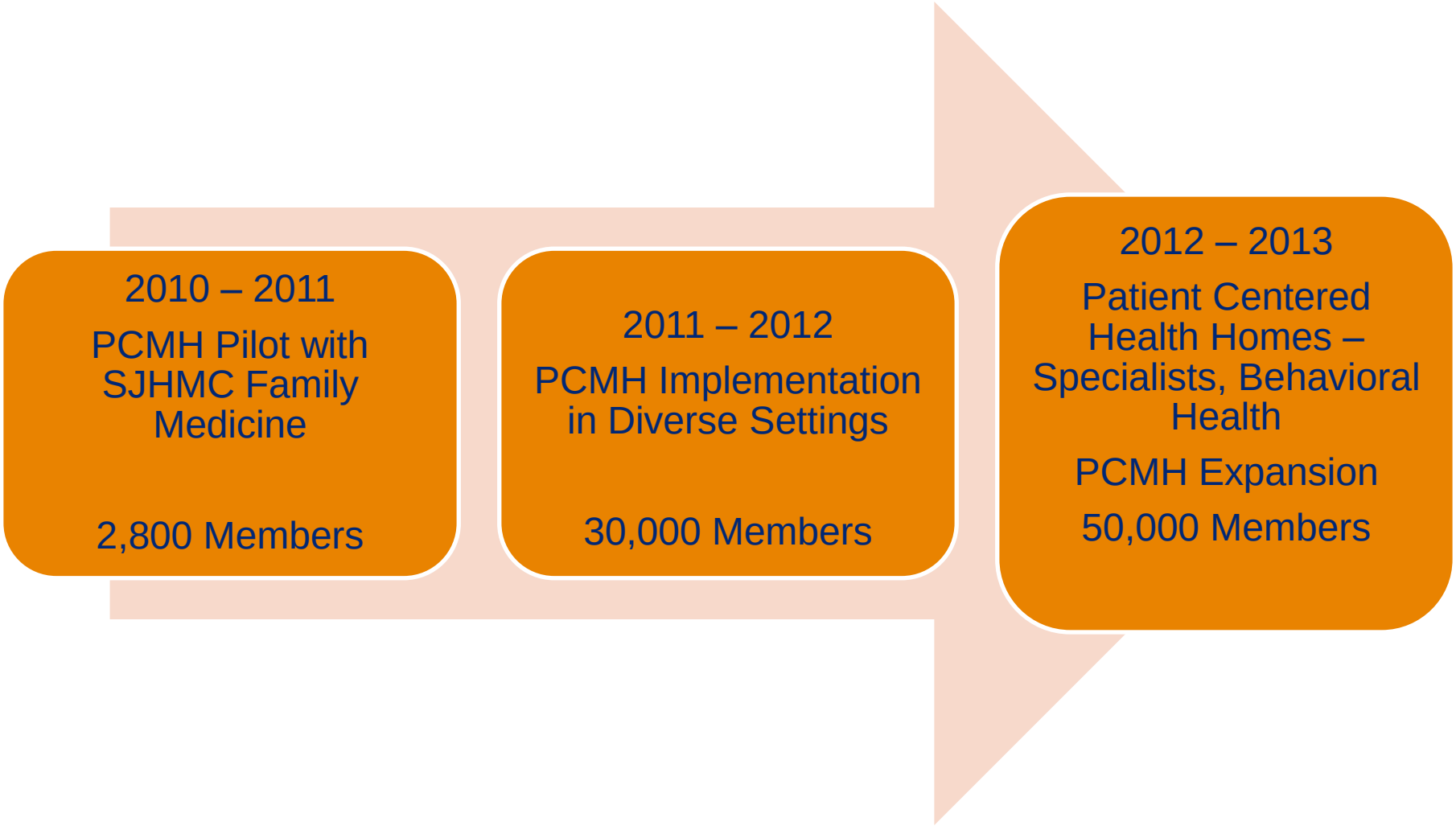
Fundamentals of the Patient Centered Medical Home Care Model

At its core, the medical home is a primary care practice that provides comprehensive care, actively engages patients in education and care delivery, offers enhanced patient access, and coordinates patient care across the continuum.



Mercy Care Plan

The Mercy Care Plan Experience



Mercy Care Plan

Early Lessons from 2011 and 2012 PCMH Implementations

- PCMH transformation is a resource intensive process- requires a champion to drive on both the plan and practice side
- Payment methodology must support the transformation through care management payments, pay for performance and enhanced fee for service where appropriate
- Member profile data is critical to bridge the gap of knowledge between the member and the provider – ED visits, medications, preventive care
- Expanded access to care changes utilization – evening and weekend hours are effective in reducing ED utilization
- Embedded case managers in collaboration with the practice group navigator/care manager form effective team to focus on high risk members

PCMH and Integrated Services

PCMH provides a care model and platform that is effective for integration of services

- Focuses on whole person and families
- Data which details all aspects of member health and utilization informs providers resulting in effective outreach and care management
- Facilitates partnerships between providers of all types of health services
- Coordination of care results in less failed appointments for specialists and behavioral health services